BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

KAREN C. ROLES	)	
Claimant	)	
VS.	)	
	)	Docket No. 270,077
THE BOEING COMPANY	)	
Respondent	)	
AND	)	
	)	
INSURANCE COMPANY OF THE STATE	)	
OF PENNSYLVANIA	)	
Insurance Carrier	)	

ORDER

Claimant and respondent appeal the June 2, 2008, Post Award Medical Award of Administrative Law Judge Thomas Klein (ALJ). Claimant was denied her requested payment of the post-award medical benefits which were listed in the Stipulation and Agreement For Purpose of November 29, 2007, Post-Award Medical Hearing (Stipulation), but she was allowed $106,339.65 in previously paid medical benefits after the ALJ found them to be necessary and reasonable, based on the evidence contained in this record. John M. Brodnan, M.D., was appointed as claimant's authorized treating physician effective November 29, 2007, pursuant to the Stipulation prepared and filed by the parties.

Claimant appeared by her attorney, Michael L. Snider of Wichita, Kansas. Respondent and its insurance carrier appeared by their attorney, Kim R. Martens of Wichita, Kansas.

The Appeals Board (Board) has considered the record and adopts the stipulations contained in the Post Award Medical Award of the ALJ. The Board also considered the transcript of the Remand Motion Hearing held July 3, 2007. The Board heard oral argument on July 18, 2008.

ISSUES

1. Did the ALJ err in finding that the $106,339.65 in previously paid medical benefits were necessary and reasonable, based on the evidence in this record? Respondent contends that claimant failed to prove that the medical treatment was both reasonable and necessary and respondent should be allowed reimbursement of the entire amount from the Kansas Workers Compensation Fund (Fund). Claimant argues that respondent failed to timely object to the payment of the medical treatment, and in the alternative, that the medical treatment was ordered by authorized health care providers and was reasonable and necessary, and respondent failed to follow the proper administrative procedures when objecting to the payment of the medical treatment before actually paying the disputed medical bills.

2. Did the ALJ err in denying payment of the medical statements contained in the Stipulation filed with the Division? Respondent argues that post-award medical requests are limited by K.S.A. 44-510k to medical bills incurred within six months of the date of the post-award application. Claimant argues that the six-month time limit does not apply to this situation.

FINDINGS OF FACT

Claimant commenced working for the respondent on January 21, 1975. Claimant has a long history of respiratory problems dating back to 1978 while working for respondent. In 1979, claimant was diagnosed with bronchiectasis. Surgery was required and Dr. Conception of Wichita, Kansas, performed a left lower lobectomy.

After the left lung operation, claimant required numerous additional medical treatments through emergency room visits and hospital admissions for continuing respiratory problems throughout the 1980s.

In 1990, because of claimant's continuing respiratory problem, she went on her own to the National Jewish Medical and Research Center (National Jewish Center) located in Denver, Colorado. The National Jewish Center is considered by many to be the nation's leading treatment center for respiratory diseases and immune disorders.

Claimant was first examined and evaluated at the National Jewish Center in December 1990 with a history of asthma being diagnosed since 1978. The National Jewish Center physicians examined claimant and diagnosed her with bronchiectasis, and various modalities of treatment were prescribed.

Claimant returned to the National Jewish Center in July 1991. At that time, claimant gave a history of returning to work for respondent in January 1991, after returning home to Wichita from the National Jewish Center in December 1990. Shortly after claimant returned to work, claimant was again hospitalized for severe respiratory symptoms. Claimant saw Joseph Jarvis, M.D., at the National Jewish Center during the July 1991 visit. He reviewed Material Safety Data Sheets of several different chemical substances that claimant was exposed to while she was employed by respondent.

Dr. Jarvis' assessment was that claimant's history was compatible with occupation-related exacerbation of her asthma condition. He opined that claimant's symptoms would very likely worsen from exposure to many of the substances contained in the Material Safety Data Sheets claimant had supplied. The doctor also opined that claimant's initial symptoms and problems with asthma could be caused by workplace exposures. Dr. Jarvis could not design appropriate equipment to protect claimant from the chemical exposure and recommended she seriously consider finding alternative employment.

In 1991, claimant was taken off work because of her continuing severe respiratory problems and she did not return to work until five years later on May 10, 1996. During that period of time, claimant was treated primarily by board certified allergist/immunologist Maurice Henry Van Strickland, M.D., pulmonologist Daniel C. Doornbos, M.D., and board certified internal medicine specialist Roberta L. Loeffler, M.D.

Claimant made a claim for workers compensation benefits, alleging chemically induced asthma. The original claim was assigned Docket No. 152,551. On February 22, 1995, claimant settled her workers compensation claim with respondent before ALJ Shannon S. Krysl. As of the date of the settlement, claimant had received $63,494 representing 228 weeks of temporary total disability benefits. Respondent had also paid medical expenses in the amount of $76,680.34. At the settlement hearing, respondent denied the compensability of the claim and claimant relinquished her rights to review and modification of the settlement award and the right to future medical treatment. Claimant received, as a strict compromise of those issues, an additional lump sum settlement in the amount of $61,500.00. This resulted in a total settlement amount of $124,994.00 or $6.00 below the statutory maximum for a permanent total disability award under K.S.A. 44-510f(a)(1).

During the time claimant was off work and was treated for her asthma condition, her respiratory problems improved. On December 21, 1995, Dr. Strickland opined that claimant's pulmonary disease had stabilized. He released claimant to work in a smoke free, chemical odor free environment at a desk job or a job not involving physical labor.

Claimant contacted respondent and the respondent returned claimant to work on May 10, 1996, as a lead person in Industrial Park Building-three (IPB-3). The working environment that claimant returned to was clean and air conditioned.

Respondent's Active Medical Recommendations/Qualifications sheets showed as of March 14, 1996, that claimant was restricted to work in a smoke free and chemical odor free environment. In 1998, additional restrictions were noted of no work in areas with irritant fumes; must work in air conditioning; and no work in areas with skin irritants without protective equipment.

In 1997, respondent moved claimant to a different area of IPB-3 that exposed claimant to chemicals contained in cleaning solvents and fumes from mini riveters. In the latter part of 2000, respondent then moved claimant to Industrial Park Building-One (IPB-1). That building was not air conditioned and was more crowded with workers and machines.

Commencing in 1999, claimant started developing upper respiratory problems with irritation in her throat and upper chest area instead of her previous symptoms which had centered in her lung area. On January 26, 1999, Dr. Doornbos had claimant undergo a flexible fiberoptic bronchoscopy diagnostic procedure because, as a result of his observations of claimant over a period of months, he suspected claimant had a vocal cord dysfunction. Dr. Doornbos' findings from the bronchoscopy procedure confirmed the presence of vocal cord dysfunction which at least partially mimics asthma.

After the bronchoscopy procedure, claimant again went to National Jewish Center for treatment in June 1999. This time, she was evaluated for possible vocal cord dysfunction. Claimant's complaints on that visit were more in her throat and upper respiratory area compared to her previous complaints involving her lungs. The National Jewish Center also had the results of the January 1999 bronchoscopy procedure that demonstrated vocal cord dysfunction.

During the June 1999 visit, claimant was examined and evaluated at the National Jewish Center by Ronald Balkissoon, M.D., Occupational and Pulmonary Medicine Staff Physician. His impression was that claimant likely had some component of irritant-induced vocal cord dysfunction along with asthma, gastroesophageal reflux and rhinosinusitis.

Dr. Doornbos, in his September 28, 2000, medical note, stated that he found claimant with a markedly hoarse voice and a fair amount of stridor as well as expiratory laryngeal wheezing. His assessment was that, although the claimant does have asthma, the majority of her current problems really relate more to her vocal cord spasms than the asthma itself. The doctor said that severe vocal cord spasms will actually obstruct the airway leading to near respiratory failure. Claimant also made the complaint to Dr. Doornbos that she was having difficulty with the environmental conditions while working at respondent. She requested that Dr. Doornbos restrict her from working around chemical fumes and that she needed an air-conditioned workspace. Dr. Doornbos wrote out a release for those work restrictions, but also felt that claimant should not be exposed to any chemicals and it would, therefore, be to her benefit to be off work entirely.

On Monday, July 16, 2001, claimant returned to work from a medical leave of absence related to a carpal tunnel release surgery. Claimant had been off work since June 30, 2001. Claimant worked July 16, 17, and 18, 2001.

Claimant testified that on July 18, she again started having breathing problems. Because of her breathing problems, claimant carried portable oxygen equipment as prescribed by Dr. Doornbos. Claimant testified that when she returned to work those three days in July, she experienced exposure to chemical fumes and graphite dust. That exposure caused her throat to close and she could not get enough air.

On July 19, claimant still was having breathing problems and called and notified respondent that she was not able to return to work that day. Claimant also was unable to return to work on Friday, July 20.

On Saturday morning, July 21, claimant experienced an acute respiratory attack at home and was taken to the hospital by ambulance. Claimant was admitted to the hospital and required intubation and was placed on a mechanical ventilator to assist her breathing. Claimant was given aerosol bronchodilators and IV steroids. Claimant improved and was extubulated and taken off the ventilator. She was discharged on July 27, 2001.

On August 4, 2001, claimant was again admitted to the hospital with marked respiratory distress. She was seen by her treating physician, Dr. Doornbos. His impression was severe vocal cord dysfunction with multiple recent severe episodes of upper airway obstruction and bronchial asthma of unclear severity. Claimant was treated with a helium-oxygen mixture and aerosol treatments. Dr. Doornbos also opined that claimant needed a tracheostomy surgery to enable her to open her breathing pathway when she was experiencing an acute respiratory attack. Claimant was discharged on August 13, 2001.

Also during the August 4, 2001 hospitalization, claimant had tracheostomy surgery where a tube was inserted to relieve obstruction of the airway and facilitate breathing. Claimant was discharged on August 13, 2001, but she was again admitted into the hospital from August 17, 2001, through August 23, 2001, with acute respiratory problems.

Claimant returned to the hospital emergency room on August 28, 2001, with complaints of cough, shortness of breath, and no improvement following breathing treatments. Dr. Doornbos examined claimant in the hospital and his impression was severe vocal cord dysfunction, status post-tracheostomy but still symptomatic.

On September 11, 2001, claimant filed an E-1 Application For Hearing alleging a series of occupational exposures beginning July 16, 2001, and continuing thereafter. That claim was assigned Docket No. 270,077 and is the subject of this claim.

At the February 5, 2002, preliminary hearing, claimant testified that her respiratory problems she suffered in 1991 through 1995 involved her lungs. But presently her problems involve her throat.

Claimant's treating physician, pulmonologist Dr. Doornbos, wrote claimant's attorney a letter dated November 26, 2001, concerning claimant's current medical status and condition.

Dr. Doornbos opined, "She has asthma, which has been for many years, slowly worsening, partly as a result of ongoing exposure to chemicals at work. . . ."[1] He went on to opine that claimant's breathing has gradually worsened to the point where she is barely able to function on a daily basis. At work, claimant over uses her voice and her symptoms could be worsening as a result of her continuing chemical exposure at work. Claimant is presently not able to work and she should never work again around any chemical fumes which is unavoidable while working for respondent.

In a letter dated February 7, 2002, Roberta L. Loeffler, M.D., wrote to claimant's attorney and opined, "I believe that exposure to solvents, chemicals, and other airborne pollutants aggravated [the] respiratory disease in this patient. . . ." The doctor concluded, "I think it is unlikely that Karen is currently able to return to work under any circumstances due to the degree of her disability secondary to her chronic lung disease."[2]

Marsha Olson, one of claimant's co-workers, testified at the January 10, 2002 preliminary hearing. Ms. Olson worked with claimant first in IPB-3 and then worked with claimant in IPB-1, after she was transferred with claimant in the first part of 2001. IPB-3 was air conditioned and climate controlled. In contrast, IPB-1 was not air conditioned and the work environment contained chemical fumes and dust. Ms. Olson testified that after claimant was transferred to IPB-1 she observed that claimant's breathing problems increased because of the chemical exposure.

Ms. Olson testified that from 1997 to 1998, claimant was doing well in the air-conditioned climate-controlled facility building small parts, and that there were no chemical fumes claimant was exposed to during 1997 or 1998. Later, after moving to another building that did not have air conditioning, claimant began having a lot more trouble breathing. During 2001, Ms. Olson worked 6 feet away from claimant. Ms. Olson was using paint, solvents and sealers, and the materials they worked on and drilled would produce black graphite dust that smelled terrible.[3] Ms. Olson testified that she observed

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[1] P.H. Trans. (Jan. 10, 2002), Cl. Ex. 1.

[2] This letter is attached to claimant's March 22, 2002 submission letter to the ALJ and is marked Exhibit D.

[3] P.H. Trans. (Jan. 10, 2002) at 17-20.

claimant having more and more difficulty breathing her last day of work at Boeing on or about Wednesday, July 18, 2001. Claimant was not able to come to work on Thursday or Friday of that week. When Ms. Olson talked to claimant on Thursday and Friday night, claimant was having problems breathing and she could hear claimant wheezing on the phone. Early Saturday morning, claimant's daughter called Ms. Olson, and she went to claimant's house. Ms. Olson called an ambulance after arriving at claimant's house, because claimant was barely breathing. Claimant was admitted to the hospital.[4]

Diana L. Pike, a 17-year veteran employee of respondent, testified that she also worked in IPB-3 and then was transferred to IPB-1. Ms. Pike started having breathing problems about a year after she transferred into IPB-1. She experienced breathing problems as a result of her exposure to the cleaning solvent MPK. The Material Safety Data Sheet for MPK indicates that MPK may cause respiratory irritation. The Material Safety Data Sheet also indicated that certain medical conditions such as asthma, bronchitis and other preexisting respiratory disorders may be aggravated by exposure to MPK.

As a result of Ms. Pike being allergic to MPK, she now works at all times with a hooded respirator. Ms. Pike also testified that claimant was exposed to MPK because claimant was the lead person and had to work around the mini riveters when parts were soaked in this cleaning solution.

Philip G. Green, claimant's supervisor while she was employed in building IPB-1, testified in this case on behalf of the respondent. He knew that claimant had breathing problems but did not know she had restrictions against working in an environment exposed to chemicals. Mr. Green testified claimant never complained to him about excessive fumes or graphite dust in the work area. Air quality tests were also taken in claimant's work area and Mr. Green testified that they showed no over exposure. Mr. Green also knew that MPK could irritate a person's respiratory system.

Mr. Green was aware that claimant had to leave work on occasion because of her breathing difficulties. Mr. Green acknowledged that he noticed the claimant demonstrated breathing difficulties by wheezing and a hoarse voice.

At respondent's insurance company's request, claimant was examined and evaluated January 23, 2002, by occupational medicine physician Allen J. Parmet, M.D. Dr. Parmet reported his findings in a report dated February 12, 2002. Before claimant's examination, Dr. Parmet was provided various medical records and reports of doctors who had examined and treated claimant for her ongoing respiratory problems. Dr. Parmet reviewed those medical records, took a history from the claimant and conducted a physical examination of claimant.

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[4] *Id*. at 27-32.

Dr. Parmet diagnosed claimant with (1) severe vocal cord dysfunction causing pseudo asthma, (2) severe controlled asthma, (3) status post surgical carpal tunnel right hand release, (4) gastroesophageal reflux and hiatus hernia, status post endoscopic Nissen application, and (5) status post cataract extraction and intraocular lense placement.

Dr. Parmet determined that claimant's vocal cord dysfunction was not related to her work environment. He opined that the etiology of the condition was idiopathic, but the gastroesophageal reflux was a major contributing factor. The doctor also concluded there is no direct toxicologic cause for the vocal cord dysfunction condition. The doctor further concluded that claimant's asthma condition was contributed to by her work-related chemical exposure as well as the gastroesophageal reflux. Dr. Parmet found the asthma condition was stable and effectively unchanged over the past 10 years.

Dr. Parmet evaluated claimant a second time, at the request of respondent, on December 21, 2004. Dr. Parmet's diagnosis remained the same as in 2002, with the exception that he now found claimant to suffer from major depression, chronic recurrent, with psychotic episodes. Dr. Parmet determined that claimant was permanently and totally disabled, in part due to claimant's work-related occupational asthma (which he rated at 51 percent to the body as a whole), in part, due to her non-work-related bronchiectasis (which he rated at 10 percent to the body as a whole), and the remainder to her non-work-related vocal cord dysfunction. His ratings were pursuant to the fourth edition of the AMA *Guides*.[5] Dr. Parmet testified that claimant was a Class IV under the AMA *Guides*, but went on to state that claimant had been a Class IV since 1993 or 1994. He stated that claimant's preexisting condition, in and of itself, was sufficient, as a natural and probable course of her life, to cause the asthma symptoms and claimant's other symptoms regardless of the environment that claimant was living in 2000 and 2001. Dr. Parmet also testified that when Dr. Strickland modified claimant's restrictions in 1995, which allowed claimant to return to work for respondent in 1996, the modifications were not realistic. Dr. Parmet acknowledged that from 1991 to 1996, claimant's condition did stabilize, but determined that claimant was not better.

Dr. Parmet did not believe that claimant's exposure to substances at work included an exposure to isocyanates. Dr. Parmet determined that claimant was not around aromatic hydrocarbons, although he agreed claimant was around ketones, specifically MPK and MEK. On cross-examination, he agreed that respondent did use paints that could release isocyanates and toluene, which is commonly used by respondent and is an aromatic hydrocarbon.

Dr. Doornbos provided the court a letter dated June 9, 2004, in which he conceded that some of claimant's lung disease had, in the past, been contributed to by chemical exposures at respondent. However, he went on to state that claimant's ongoing worsening

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[5] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.).

of her lung disease over the previous 4 years was not due to a new injury suffered by exposures to chemicals with respondent, but rather due to the ongoing outworking of her severe asthma and bronchiectasis and also probably due to claimant's ongoing acid aspiration with progressive lung deterioration. Dr. Doornbos did testify that claimant's chances of maintaining even a reasonable semblance of health when exposed to noxious fumes on a regular basis would be almost nil. He stated that no exposure to irritant chemicals does an asthmatic any good, whether the chemical be Barsol 11-7, MPK, cigarette smoke in a bar or diesel fumes in traffic. No inhaled irritant would be good for claimant. He conceded that if claimant was being exposed to such irritants, it certainly could have a negative effect on her breathing. Dr. Doornbos also acknowledged that, in 1994, when he repeated the pulmonary function tests on claimant, her FEV-1 had increased 163 percent, which he described as a huge positive improvement.

In late April 2003, claimant moved to Florida. She was first examined by board certified internal medicine specialist Felix A. Sosa, M.D., on May 19, 2003. Dr. Sosa diagnosed claimant with interstitial lung disease (ILD). He described this as scarring of her lungs from chemical exposure. Dr. Sosa stated this condition was permanent, claimant would not get better, and ultimately claimant would need a lung transplant. He was provided a Material Safety Data Sheet pertaining to Barsol A-2904, which he stated contained hydrocarbons. Dr. Sosa testified that hydrocarbon is a textbook chemical risk for ILD. Dr. Sosa testified that claimant is permanently disabled as a result of her multiple occupational exposures to the chemicals at respondent's facility.

Claimant returned to Dr. Strickland on June 21, 2005, at the request of her attorney. Dr. Strickland initially treated claimant from February 11, 1991, through March 19, 1998, and had, early on, recommended that claimant leave respondent's aircraft plant because he thought her work exposure was making her asthma worse. When claimant asked Dr. Strickland in 1995 for permission to return to work with respondent, which she did in 1996, he told her that she could not go back into that environment because of the chemicals and irritants. Claimant advised that she could get an office job with air conditioning, no smoke, solvent or chemical exposure, and that she would be able to avoid irritants and paint. When claimant returned to respondent, she did well the first few years. Her asthma was being controlled. However, according to Dr. Strickland's review of the records, claimant's worsening condition was connected to the move to an environment where claimant was exposed to chemicals. Dr. Strickland also noted that claimant's respiratory system findings in 2005 were different from what he noted from 1995 to 1998. The differences he noticed were the ground-glass opacities, ILD and subpleural nodules. The diagnosis of ILD was new, and claimant's lung damage was worse. He reviewed a CT scan taken at Wesley Medical Center on June 21, 2005. The radiologist's report described fibrosis with some ground-glass opacity in the right upper lobe. Dr. Strickland, who reviewed the actual CT scan, noted that claimant had terrible scarring and damage to her lungs. He also opined that this type of fibrosis is very consistent with the exposures that claimant had with respondent. He testified that 75 percent of claimant's current condition is due to claimant's second time working with respondent. Dr. Strickland went on to say

that claimant is permanently and totally disabled, and has been so since her last date of employment with respondent.

The Board, in its Order of April 30, 2007, found claimant to be permanently and totally disabled from working. One of the issues presented to the Board at that time involved past medical benefits in the amount of $106,339.65. The Board found that the ALJ had failed to consider this issue, even though it had been raised by respondent at the regular hearing. Attached to that regular hearing transcript was Respondent's Exhibit 6, a detailed list of medical benefits paid by respondent, yet disputed as to whether those benefits were reasonable and necessary based on the medical information contained in this record. Respondent had requested reimbursement from the Fund for the full amount of the benefits already paid. As the Board is limited to reviewing issues presented to and decided by an administrative law judge pursuant to K.S.A. 2006 Supp. 44-551, the Board determined that it did not have the jurisdiction to determine, first impression, the issues dealing with the disputed medical treatment and respondent's request for reimbursement. The matter was remanded to the ALJ for a determination of the necessity and reasonableness of the medical expenses as claimed by respondent, "based on the exhibits and evidence contained in this record".[6]

A Remand Motion Hearing was held by the ALJ on July 3, 2007. At that hearing, respondent argued, and the ALJ agreed, that the parties were limited to the record as previously presented, pursuant to the Order of the Board. Also at that hearing, the attorney for respondent and its insurance company argued that the disputed medical bills were constantly being presented to respondent from the health care providers in Florida, where claimant was then residing, and a penalties demand would always accompany the bills. This placed respondent "under the gun," so to speak, to get the bills paid quickly or face the possibility of penalties on substantial amounts of medical bills. Respondent also argued that on many occasions, there were no medical reports with the bills. Respondent argued that many of the bills were from medical procedures not related to claimant's injuries suffered while working for respondent. Respondent requested that claimant provide citations, pages, exhibit numbers and other information in the record that would support the payment of these bills as reasonable and necessary to the treatment of claimant's work-related injuries.

Claimant argued that Kansas law does not require medical testimony to support every bill submitted during workers compensation litigation. When claimant offered to provide testimony regarding the bills from 2004 and 2005, and their relationship to her work-related injuries, the ALJ refused to reopen the record, citing the Board's previous Order. However, also in dispute were numerous medical bills incurred while claimant was residing in Florida. Those bills, attached to Claimant's Motion For Payment Of Medical Expenses On Remand, were presented to the ALJ at the Remand Motion Hearing, but not

[6] Board's Order dated April 30, 2007, at 16.

actually placed into the record. Claimant was allowed to testify regarding those bills, although over respondent's objection. The ALJ noted that claimant had returned from Florida to testify and was present that day. Finding that respondent was aware of claimant's request for payment of those bills, the ALJ allowed claimant to testify regarding certain post-award medical requests filed by claimant. No additional testimony regarding the Board's remand was allowed. Claimant's testimony detailed the medical treatment and bills contained in the later Stipulation filed by the parties with the Division on November 29, 2007. Claimant identified Dr. Brodnan as her authorized treating physician in Florida. Respondent acknowledged at the Preliminary and Motion Hearing on February 15, 2005, that Dr. Brodnan was claimant's authorized physician. After claimant discussed the medical bills in some detail, it was noted by the ALJ that the medical testimony of the doctors would still be required in order to establish the reasonableness and necessity of the medical treatment detailed in the medical bills. However, these issues were rendered moot by the parties' Stipulation.

On July 6, 2007, claimant filed an Application For Post Award Medical, form K-WC E-4, with the Division. The matter came before the ALJ on November 29, 2007, at which time the parties filed the Stipulation. It is noted in the transcript of the Post Award Hearing that this is a completely separate matter from the Remand Motion Hearing. The parties acknowledged that the Stipulation contained all of the evidence necessary for the ALJ to decide the post-award medical issues. Respondent argued that, under K.S.A. 44-510k, claimant was limited to medical treatment relating no more than six months preceding the claimant's application for post-award medical treatment. From the date of the filing of the application, six months back would be January 6, 2007. Respondent correctly noted that the entirety of the medical bills contained in the Stipulation were outside that six-month window and, therefore, respondent argued that claimant was not entitled to payment of any of the stipulated medical bills. Further, as the Award of the ALJ originally awarded future medical upon application to the Director, and as the Board merely affirmed that portion of the ALJ's Award, the medical in question was not authorized without the ALJ's Order. Respondent agreed that any bills incurred after January 6, 2007, would be covered under the post-award medical statute.

Claimant argued that as the matter was still on remand from the Award of the ALJ, and as no final decision had been made, the six-month rule did not apply as this matter is not post award.

On June 2, 2008, the ALJ issued a Post Award Medical Award in this matter. The Award determined that claimant had not filed her Application For Post Award Medical in a timely fashion and the entirety of the medical bills listed in the Stipulation were denied. All of the bills contained in the Post Award record related back more than six months from the time of the filing of the Post Award Medical request. The Post Award Medical Award did echo the Stipulation in that Dr. Brodnan was made the authorized treating physician from November 29, 2007, and forward.

The ALJ never issued a separate order dealing with the remand from the Board. Instead, in the middle of the Post Award Medical Award, the following paragraph was inserted:

> The Court finds that the Claimant has met her burden to establish that the medical treatment she has incurred are necessary and reasonable based on the evidence contained in the record and finds no reason to reimburse Respondent for any of the $106,339.65 previously paid in this matter.[7]

The unusual procedure incorporated by the ALJ is confusing, as the transcript from the Remand Motion Hearing was not listed as part of the record being considered by the ALJ. While this procedure is unorthodox, neither party objected to the format when arguing the matter before the Board. However, claimant did mistakenly comment in her brief to the Board that the ALJ had not and apparently would not address the previous medical benefits and bills incurred during the pendency of this litigation. The Board notes the ALJ did address in the Post Award Medical Award the issues presented at both the Remand Motion Hearing and the Post Award Hearing.

Claimant appealed the denial of the post-award medical payments contained in the Stipulation. Respondent appealed the ALJ's finding that claimant had met her burden to establish that the medical treatment incurred in the amount of $106,339.65 was reasonable and necessary. The ALJ denied respondent's motion for reimbursement from the Fund of the $106,339.65 in medical expenses already paid in this matter.

PRINCIPLES OF LAW AND ANALYSIS

K.S.A. 44-510k(b) states in part:

> Any application for hearing made pursuant to this section shall receive priority setting by the administrative law judge, only superseded by preliminary hearings pursuant to K.S.A. 44-534a and amendments thereto. The parties shall meet and confer prior to the hearing pursuant to this section, but a prehearing settlement conference shall not be necessary. The administrative law judge shall have authority to award medical treatment relating back to the entry of the underlying award, but in no event shall such medical treatment relate back more than six months following the filing of such application for post-award medical treatment.[8]

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[7] Post Award Medical Award of June 2, 2008, at 2.

[8] K.S.A. 44-510k(b).

The ALJ determined that claimant was not entitled to payment for the medical bills listed in the Stipulation filed with the Division. The justification stemmed from claimant's failure to apply for the post-award benefits within six months of the original Award. K.S.A. 44-510k does prohibit an award of medical treatment relating back more than six months before the filing of the post-award medical treatment application. However, in this instance, claimant is not applying for medical treatment. She is requesting payment for medical treatment provided under the supervision of the authorized treating physician, Dr. Brodnan. Dr. Brodnan has been the authorized treating physician since at least the Preliminary and Motion Hearing of February 15, 2005. All of the stipulated medical bills were incurred after that date. Additionally, the Stipulation identifies the medical bills as being reasonable and necessary for claimant's treatment, the charges are related to claimant's work-related occupational disease, and the charges are stipulated as being reasonable and customary charges, to the extent that they comport to the Kansas Medical Fee Schedule.

K.A.R. 51-9-7 states:

> Fees for medical, surgical, hospital, dental, and nursing services, medical equipment, medical supplies, prescriptions, medical records, and medical testimony rendered pursuant to the Kansas workers compensation act shall be the lesser of the usual and customary charge of the health care provider, hospital, or other entity providing the health care services or the amount allowed by the "workers compensation schedule of medical fees" published by the Kansas department of labor and dated December 1, 2005, including the ground rules incorporated in the schedule, which is hereby adopted by reference.
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> This regulation shall be effective on and after December 1, 2005.[9]

The only exception in the Stipulation relates to the medical bills from the Florida Institute of Health in the amount of $93.76 and Wuesthoff Home Medical Equipment for $498.16. The Stipulation notes the absence of any medical records establishing the treatment forming the basis for these charges was related to claimant's work-related occupational disease.

The Board finds respondent's position on this issue and the ruling of the ALJ are misplaced. There is no six-month rule under K.S.A. 44-510k for ongoing medical treatment with the authorized treating physician. The language of that statute applies to a claimant's request for newly authorized medical treatment, post award. There was no need for claimant to request medical treatment here, as it was already being furnished by the physician designated as the treater by respondent. As such, the Board finds the medical bills listed in the Stipulation are the responsibility of respondent and its insurance company, with the exception of the December 27, 2006, bill from the Florida Institute of Health for $93.76 and the Wuesthoff Home Medical Equipment bill for $498.16, as claimant failed to

[9] K.A.R. 51-9-7.

satisfy her burden of proving a relationship between those and her work-related occupational disease. The medical bills contained in the Stipulation are subject to the Kansas Medical Fee Schedule, and any dispute in that regard is to be determined pursuant to K.S.A. 2001 Supp. 44-510i. The decision of the ALJ on this issue is reversed.

As noted above, the ALJ also determined, in the Post Award Medical Award, the issue dealing with $106,339.65 in pre-award medical treatment. While this matter could be remanded to the ALJ for a specific order on that issue, judicial economy encourages a decision by the Board without the necessity of an additional hearing below. This matter has now been before the Board on six occasions and has been in litigation, with the inclusion of the original occupational disease, for thirty years. Claimant's original diagnosis of bronchiectasis was made in 1979. The file has also grown to immense proportions, being perhaps the largest record ever reviewed by this Board.

Respondent argues that claimant has been on notice that there is a dispute regarding the relationship of these medical bills and claimant's work-related occupational disease.

K.S.A. 44-510j states:

> When an employer's insurance carrier or a self-insured employer disputes all or a portion of a bill for services rendered for the care and treatment of an employee under this act, the following procedures apply:
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> (a) (1) The employer or carrier shall notify the service provider within 30 days of receipt of the bill of the specific reason for refusing payment or adjusting the bill. Such notice shall inform the service provider that additional information may be submitted with the bill and reconsideration of the bill may be requested. The provider shall send any request for reconsideration within 30 days of receiving written notice of the bill dispute. If the employer or carrier continues to dispute all or a portion of the bill after receiving additional information from the provider, the employer, carrier or provider may apply for an informal hearing before the director.
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> (2) If a provider sends a bill to such employer or carrier and receives no response within 30 days as allowed in subsection (a) and if a provider sends a second bill and receives no response within 60 days of the date the provider sent the first bill, the provider may apply for an informal hearing before the director.
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> (3) Payments shall not be delayed beyond 60 days for any amounts not in dispute. Acceptance by any provider of a payment amount which is less than the full amount charged for the services shall not affect the right to have a review of the claim for the outstanding or remaining amounts.
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> (b) The application for informal hearing shall include copies of the disputed bills, all correspondence concerning the bills and any additional written information the party deems appropriate. When anyone applies for an informal hearing before the director, copies of the application shall be sent to all parties to the dispute and the employee. Within 20 days of receiving the application for informal hearing, the

other parties to the dispute shall send any additional written information deemed relevant to the dispute to the director.

(c) The director or the director's designee shall hold the informal hearing to hear and determine all disputes as to such bills and interest due thereon. Evidence in the informal hearing shall be limited to the written submissions of the parties. The informal hearing may be held by electronic means. Any employer, carrier or provider may personally appear in or be represented at the hearing. If the parties are unable to reach a settlement regarding the dispute, the officer hearing the dispute shall enter an order so stating.

(d) After the entry of the order indicating that the parties have not settled the dispute after the informal hearing, the director shall schedule a formal hearing.

(1) Prior to the date of the formal hearing, the director may conduct a utilization review concerning the disputed bill. The director shall develop and implement, or contract with a qualified entity to develop and implement, utilization review procedures relating to the services rendered by providers and facilities, which services are paid for in whole or in part pursuant to the workers compensation act. The director may contract with one or more private foundations or organizations to provide utilization review of service providers pursuant to the workers compensation act. Such utilization review shall result in a report to the director indicating whether a provider improperly utilized or otherwise rendered or ordered unjustified treatment or services or that the fees for such treatment or services were excessive and a statement of the basis for the report's conclusions. After receiving the utilization review report, the director also may order a peer review. A copy of such reports shall be provided to all parties to the dispute at least 20 days prior to the formal hearing. No person shall be subject to civil liability for libel, slander or any other relevant tort cause of action by virtue of performing a peer or utilization review under contract with the director.

(2) The formal hearing shall be conducted by hearing officers, the medical administrator or both as appointed by the director. During the formal hearing parties to the dispute shall have the right to appear or be represented and may produce witnesses, including expert witnesses, and such other relevant evidence as may be otherwise allowed under the workers compensation act. If the director finds that a provider or facility has made excessive charges or provided or ordered unjustified treatment, services, hospitalization or visits, the provider or facility may, subject to the director's order, receive payment pursuant to this section from the carrier, employer or employee for the excessive fees or unjustified treatment, services, hospitalization or visits and such provider may be ordered to repay any fees or charges collected therefor. If it is determined after the formal hearing that a provider improperly utilized or otherwise rendered or ordered unjustified treatment or services or that the fees for such treatment or services were excessive, the director may provide a report to the licensing board of the service provider with full documentation of any such determination, except that no such report shall be provided until after judicial review if the order is appealed. Any decision rendered under this section may be reviewed by the workers compensation board. A party must file a notice of appeal within 10 days of the issuance of any decision under this section. The record on appeal shall be limited only to the evidence presented to

the hearing officer. The decision of the director shall be affirmed unless the board determines that the decision was not supported by substantial competent evidence.

(e) By accepting payment pursuant to this section for treatment or services rendered to an injured employee, the provider shall be deemed to consent to submitting all necessary records to substantiate the nature and necessity of the service or charge and other information concerning such treatment to utilization review under this section. Such health care provider shall comply with any decision of the director pursuant to this section.

(f) Except as provided in K.S.A. 60-437 and amendments thereto and this section, findings and records which relate to utilization and peer review conducted pursuant to this section shall be privileged and shall not be subject to discovery, subpoena or other means of legal compulsion for release to any person or entity and shall not be admissible in evidence in any judicial or administrative proceeding, except those proceedings authorized pursuant to this section. In any proceedings where there is an application by an employee, employer, insurance carrier or the workers compensation fund for a hearing pursuant to K.S.A. 44-534a, and amendments thereto, for a change of medical benefits which has been filed after a health care provider, employer, insurance carrier or the workers compensation fund has made application to the medical services section of the division for the resolution of a dispute or matter pursuant to the provisions of this section, all reports, information, statements, memoranda, proceedings, findings and records which relate to utilization and peer review including the records of contract reviewers and findings and records of the medical services section of the division shall be admissible at the hearing before the administrative law judge on the issue of the medical benefits to which an employee is entitled.

(g) A provider may not improperly overcharge or charge for services which were not provided for the purpose of obtaining additional payment. Any dispute regarding such actions shall be resolved in the same manner as other bill disputes as provided by this section. Any violation of the provisions of this section or K.S.A. 44-510i, and amendments thereto, which is willful or which demonstrates a pattern of improperly charging or overcharging for services rendered pursuant to this act constitutes grounds for the director to impose a civil fine not to exceed $5,000. Any civil fine imposed under this section shall be subject to review by the board. All moneys received for civil fines imposed under this section shall be deposited in the state treasury to the credit of the workers compensation fund.

(h) Any health care provider, nurse, physical therapist, any entity providing medical, physical or vocational rehabilitation services or providing reeducation or training pursuant to K.S.A. 44-510g and amendments thereto, medical supply establishment, surgical supply establishment, ambulance service or hospital which accept the terms of the workers compensation act by providing services or material thereunder shall be bound by the fees approved by the director and no injured employee or dependent of a deceased employee shall be liable for any charges above the amounts approved by the director. If the employer has knowledge of the injury and refuses or neglects to reasonably provide the services of a health care provider required by this act, the employee may provide the same for such employee, and the employer shall be liable for such expenses subject to the regulations adopted by the director. No action shall be filed in any court by a health

> care provider or other provider of services under this act for the payment of an amount for medical services or materials provided under the workers compensation act and no other action to obtain or attempt to obtain or collect such payment shall be taken by a health care provider or other provider of services under this act, including employing any collection service, until after final adjudication of any claim for compensation for which an application for hearing is filed with the director under K.S.A. 44-534 and amendments thereto. In the case of any such action filed in a court prior to the date an application is filed under K.S.A. 44-534 and amendments thereto, no judgment may be entered in any such cause and the action shall be stayed until after the final adjudication of the claim. In the case of an action stayed hereunder, any award of compensation shall require any amounts payable for medical services or materials to be paid directly to the provider thereof plus an amount of interest at the rate provided by statute for judgments. No period of time under any statute of limitation, which applies to a cause of action barred under this subsection, shall commence or continue to run until final adjudication of the claim under the workers compensation act.
>
> (i) As used in this section, unless the context or the specific provisions clearly require otherwise, "carrier" means a self-insured employer, an insurance company or a qualified group-funded workers compensation pool and "provider" means any health care provider, vocational rehabilitation service provider or any facility providing health care services or vocational rehabilitation services, or both, including any hospital.[10]

When there is a dispute with all or a portion of a medical bill, the procedures are clearly set out above. Respondent argues that the medical bills in question, as listed in Respondent's Exhibit 6 from the Regular Hearing, were presented on numerous occasions accompanied by a K.S.A. 44-512a demand. As such, respondent paid these medical bills "under the gun", so to speak. The medical bills in dispute are listed in Respondent's Exhibit 6 with a total paid of $106,339.65. However, that is the amount listed in respondent's column marked as "Amount Paid". Next to that column is a second column marked "Original Amount". This column computes to a total of $146,234.85. This represents a reduction from the original amount of $39,895.20. Of the 64 original items in these columns, 5 were without an original amount, 9 had the same number in both the original amount column and the paid column, and 50 showed a reduction from the original amount to the paid amount column. These reductions were taken without explanation in this record. Respondent contends that it was forced to pay these amounts under the gun or face the possibility of penalties under K.S.A. 44-512a. Yet, there was enough time for someone with respondent to determine that a reduction of 27 percent was in order. There is no indication in this record that respondent, at any time, presented medical bills to any service provider with notification of a dispute regarding all or any part of a bill. There was never a request for additional information or a request for reconsideration of a bill.

[10] K.S.A. 44-510j.

K.S.A. 44-512a states:

> (a) In the event any compensation, including medical compensation, which has been awarded under the workers compensation act, is not paid when due to the person, firm or corporation entitled thereto, the employee shall be entitled to a civil penalty, to be set by the administrative law judge and assessed against the employer or insurance carrier liable for such compensation in an amount of not more than $100 per week for each week any disability compensation is past due and in an amount for each past due medical bill equal to the larger of either the sum of $25 or the sum equal to 10% of the amount which is past due on the medical bill, if: (1) Service of written demand for payment, setting forth with particularity the items of disability and medical compensation claimed to be unpaid and past due, has been made personally or by registered mail on the employer or insurance carrier liable for such compensation and its attorney of record; and (2) payment of such demand is thereafter refused or is not made within 20 days from the date of service of such demand.
>
> (b) After the service of such written demand, if the payment of disability compensation or medical compensation set forth in the written demand is not made within 20 days from the date of service of such written demand, plus any civil penalty, as provided in subsection (a), if such compensation was in fact past due, then all past due compensation and any such penalties shall become immediately due and payable. Service of written demand shall be required only once after the final award. Subsequent failures to pay compensation, including medical compensation, shall entitle the employee to apply for the civil penalty without demand. The employee may maintain an action in the district court of the county where the cause of action arose for the collection of such past due disability compensation and medical compensation, any civil penalties due under this section and reasonable attorney fees incurred in connection with the action.
>
> (c) The remedies of execution, attachment, garnishment or any other remedy or procedure for the collection of a debt now provided by the laws of this state shall apply to such action and also to all judgments entered under the provisions of K.S.A. 44-529 and amendments thereto, except that no exemption granted by any law shall apply except the homestead exemption granted and guaranteed by the constitution of this state.[11]

K.S.A. 44-512a allows penalties on amounts which are past due and unpaid. The procedures under K.S.A. 44-510j are for the purpose of determining the amounts due and owing. No penalties would be appropriate during the dispute process. Respondent's failure to contest any of the bills pursuant to K.S.A. 44-510j, along with the clear reduction in the original amounts without explanation, cause its arguments on this issue to ring disingenuous.

[11] K.S.A. 44-512a.

K.A.R. 51-9-10 states:

> (a) Upon the completion of treatment in all compensation cases, physicians shall promptly notify the employer or carrier, and shall render their final bills forthwith. Bills for medical care providers and hospitals shall be itemized showing the date and the charge for services rendered. Separate bills should be presented to the employer or carrier by each surgeon, assistant, anesthetist, consultant, hospital, or nurse. In cases requiring prolonged treatment, physicians should submit partial bills, fully itemized, at intervals of at least 60 days.
>
> (b)(1) Medical reports of the physician should be submitted on a periodic basis depending upon the nature and severity of the injuries involved and, in all cases, immediately upon request of the respondent or insurance carrier. A report shall be rendered on the date on which the physician releases the worker to return to work and forwarded to the employer or insurance carrier and to the employee, if requested.
>
> (2) In cases of amputation, the physician shall mark the exact point of amputation on a diagram showing the member involved.
>
> (3) The patient privilege preventing the furnishing of medical information by doctors and hospitals is waived by a worker seeking workers compensation benefits, and all reports, records, or other data concerning examinations or treatment shall be furnished to the employer or insurance carrier or the director at that individual's request without the necessity of a release by the worker.
>
> (4) Unreasonable refusal by the worker to cooperate with the employer or insurance carrier or the director by failing to furnish medical information releases for the worker's medical history may result in compensation being denied or terminated after hearing before the director.
>
> (5) The employee shall immediately be furnished a copy of any medical report that authorizes return to work.
>
> (c) Nurses, whether registered or practical, shall be furnished in an institution or the worker's home when the treating doctor recommends this nursing care. Nursing service by a member of the worker's family shall be provided if approved in advance by the treating physician.[12]

Any bills presented in violation of the above regulation would allow for immediate objection by respondent under K.S.A. 44-510j. Again, there is no evidence that respondent chose to employ that procedure to redress its concerns.

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Post Award Medical Award of the ALJ should be reversed with regard to the Stipulation and the post-award medical bills, with the exception of the medical bills set out above, but

[12] K.A.R. 51-9-10.

affirmed with regard to the pre-award disputed medical bills in the amount of $106,339.65. The medical bills contained in the Stipulation are not controlled by the six-month rule in K.S.A. 44-510k. Respondent is ordered to pay the medical bills contained in the Stipulation, pursuant to the Kansas Medical Fee Schedule, with the exception of the bills from the Florida Institute of Health in the amount of $93.76 and Wuesthoff Home Medical Equipment for $498.16.

Additionally, respondent has failed to provide justification for its failure to follow the procedures contained in K.S.A. 44-510j. Therefore, the determination by the ALJ that $106,339.65 in medical treatment is reasonable and necessary to treat claimant's work-related occupational disease is affirmed.

AWARD

WHEREFORE, it is the finding, decision, and order of the Appeals Board that the Post Award Medical Award of Administrative Law Judge Thomas Klein dated June 2, 2008, should be, and is hereby, reversed with regard to the medical amounts contained in the "Stipulation And Agreement For Purpose Of November 29, 2007, Post Award Medical Hearing", with the exception of the medical bills for the Florida Institute of Health in the amount of $93.76 and Wuesthoff Home Medical Equipment for $498.16. The Award of the ALJ is affirmed with regard to the pre-award medical bills in the amount of $106,339.65.

IT IS SO ORDERED.

Dated this ____ day of March, 2009.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: Michael L. Snider, Attorney for Claimant
Kim R. Martens, Attorney for Respondent and its Insurance Carrier
Thomas Klein, Administrative Law Judge